

MEDICARE ADVANTAGE PROGRAM PAYMENT SYSTEM

payment**basics**

Revised:
October 2012

The Medicare Advantage (MA) program allows Medicare beneficiaries to receive their Medicare benefits from private plans rather than from the traditional fee-for-service (FFS) program. Under some MA plans, beneficiaries may receive additional benefits beyond those offered under traditional Medicare and may pay additional premiums for them. Medicare pays plans a capitated rate for the 26 percent of beneficiaries enrolled in MA plans in 2012. These payments amounted to \$124 billion in 2011.

Available MA plans include health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service (PFFS) plans, and special needs plans (SNPs). For payment purposes, there are two different categories of MA plans: local plans and regional plans. Local plans may be any of the available plan types and may serve one or more counties. Medicare pays them based on their enrollees' counties of residence. Regional plans, however, must be PPOs and must serve all of one of the 26 regions established by the Centers for Medicare & Medicaid Services (CMS). Each region comprises one or more entire states.

Defining the Medicare Advantage products Medicare buys

Under the MA program, Medicare buys insurance coverage for its beneficiaries from private plans with payments made monthly. The coverage must include all Medicare Part A and Part B benefits except hospice. All plans, except PFFS plans, must also offer an option that includes the Part D drug benefit. Plans may limit enrollees' choices of providers more narrowly than under the traditional fee-for-service (FFS) program. Plans may supplement Medicare benefits by reducing

cost-sharing requirements, providing coverage of non-Medicare benefits, or providing a rebate of all or part of the Part B or Part D premium. To pay for these additional benefits, plans must use their cost savings in providing the Medicare benefit and may charge a supplemental premium.

Determining Medicare payment for local MA plans

Plan bids partially determine the Medicare payments they receive (Figure 1). Plans bid to offer Parts A and B (Part D coverage is handled separately) coverage to Medicare beneficiaries. The bid here is presented as the bid to cover an average, or standard, beneficiary. The bid will include plan administrative cost and profit. CMS bases the Medicare payment for a private plan on the relationship between its bid and benchmark.

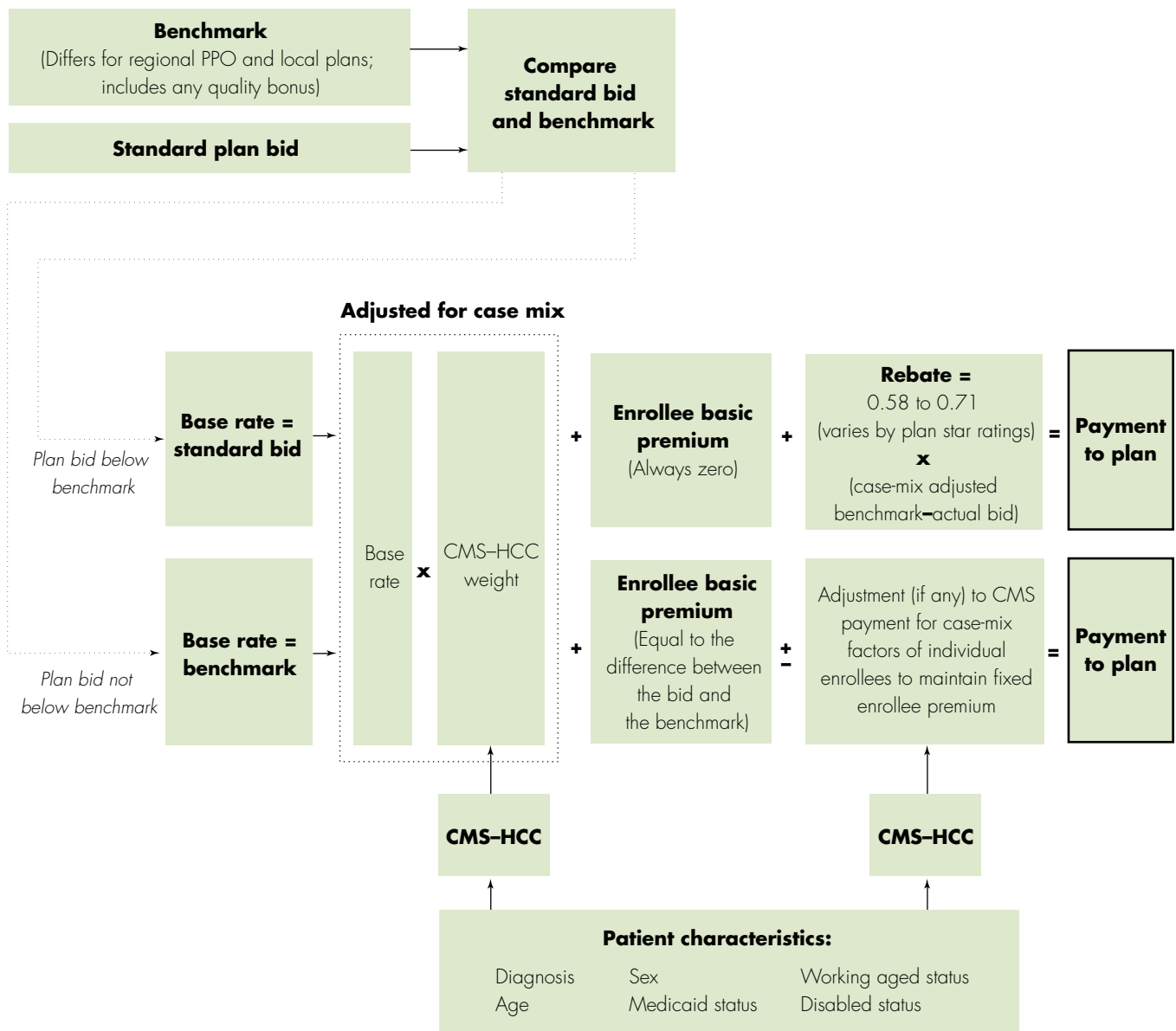
The benchmark is a bidding target. The local MA benchmarks are determined under statutory formulas whereby county-level rates vary depending on several factors. In 2012 and thereafter, through changes made in the Patient Protection and Affordable Care Act of 2010 (PPACA), the factors determining the benchmark levels include the relationship between a county's per capita program expenditures for beneficiaries in traditional FFS Medicare and the national average level of FFS program expenditures, as well as plan quality indicators. The years 2012 through 2016 are transition years in which benchmarks will be a blend of the rates determined under pre-PPACA provisions and benchmarks determined under the new payment system that will be in full effect in all counties as of 2017.¹ The benchmark will also vary from plan to plan depending on a plan's ranking in the CMS star system that measures the quality of

*This document does not
reflect proposed legislation
or regulatory actions.*

MedPAC

425 Eye Street, NW
Suite 701
Washington, DC 20001
ph: 202-220-3700
fax: 202-220-3759
www.medpac.gov

Figure 1 Medicare Advantage payment system for nondrug benefits, 2013



Note: PPO (preferred provider organization), CMS-HCC (CMS-hierarchical condition category). If the plan bid equals the benchmark, there is no enrollee basic premium. Medicare payments also reflect an intra-service area adjustment based on the county of residence of the enrollee.

care that plans provide. Plans with higher quality rankings will have bonus amounts added to benchmark levels. In certain counties—urban areas with low FFS expenditure levels and historically high Medicare managed care enrollment—plans with high star rankings can have their benchmark bonuses doubled.

During the transition period there will be a blended benchmark with two components, a portion of the benchmark determined under pre-PPACA rules and a portion determined under the new system. The share for each component will depend on how great the difference would have been between benchmarks computed under

each of the two systems when applied as of 2010. For 2013 benchmarks, the new system will be fully in effect for counties with the smallest difference between the two components of the blended benchmark levels (a difference of under \$30 between the pre-PPACA computation and the computation under the new system when applied as of 2010). For counties in which the difference is \$30 or more and less than \$50, the transition will be four years, with the new system fully implemented in 2015, and the 2013 benchmark blend set at 1/2 of the pre-PPACA computed amount and 1/2 under the new system. For six-year transition counties—where the difference is greater than or equal to \$50—the 2013 blend is 2/3 (4/6) based on the pre-PPACA computed amount and 1/3 (2/6) under the new system. There is also a statutory cap on the blended benchmark amount whereby the blended amount for transition years may not exceed the level of the benchmark amount determined under pre-PPACA rules. For the period 2012–2014, CMS has implemented a demonstration applicable to all plans for which bonus payments based on star ratings would be above those specified in the statute, and the cap on blended benchmarks would not apply to these plans. Regional benchmarks are based on the local benchmarks and are discussed in detail later in this document.

If a plan's standard bid is above the benchmark, then the plan receives a base rate equal to the benchmark and the enrollees have to pay a basic premium that equals the difference between the bid and the benchmark. The base rate for a plan bidding at the benchmark is the benchmark. If a plan bid falls below the benchmark, the plan receives a base rate equal to its standard bid.

Medicare payments are also based on enrolled beneficiaries' demographics and health risk characteristics. Medicare uses beneficiaries' characteristics, such as age and prior health conditions, and a risk-adjustment model—the CMS–hierarchical condition category (CMS–HCC)—to develop a measure of their expected relative risk for covered Medicare spending. The payment

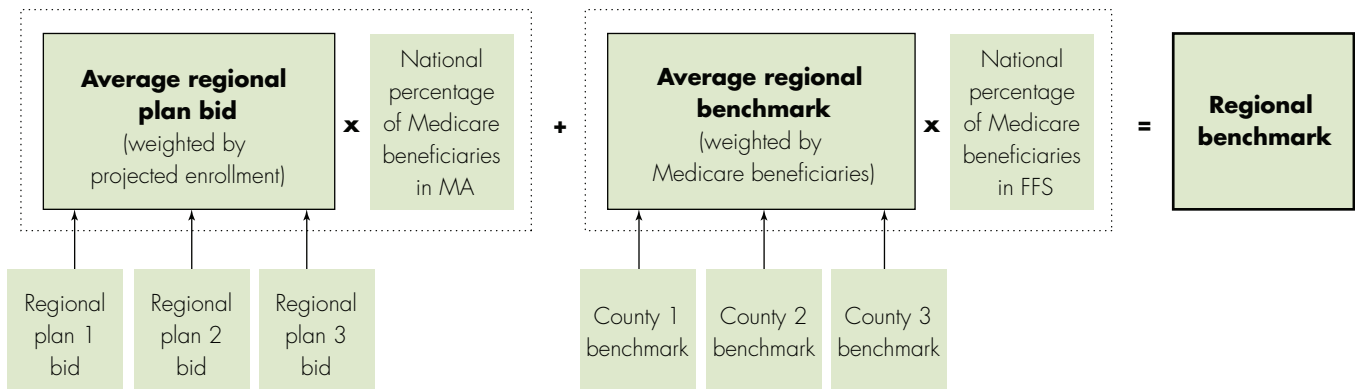
for an enrollee is the base rate for the enrollee's county of residence, multiplied by the enrollee's risk measure, also referred to as the CMS–HCC weight.

Plans that bid below the benchmark also receive payment from Medicare in the form of a “rebate.” The law defines the rebate as a fixed percentage of the difference between the plan's actual bid (not standardized) and its case-mix-adjusted benchmark. As of 2014 and thereafter, the fixed percentages will be 50, 65 and 70 percent, depending on a plan's star rating. The years 2012 and 2013 are transition years. In 2013, the fixed percentage is (a) 75 percent, applied to one-third of the difference between the bid and the benchmark, and (b) for the remaining two-thirds, a percentage that will vary depending on the plan star ratings. For 2013 this results in rebate percentages ranging from 58 to 71 percent (rounded). Once the rebate dollars are determined, the plan must then return the rebate to its enrollees in the form of supplemental benefits or lower premiums. The plan can apply any premium savings to the Part B premium (in which case the government retains the amount for that use), to the Part D premium, or to the premium for the total package that may include supplemental benefits.

For plans bidding at or above the benchmark, there are no rebates. If a plan bids above the benchmark, the enrollee pays a premium equal to the difference between the standardized benchmark and the standardized bid. Medicare's payment to the plan is the case-mix-adjusted benchmark. For plans with a case mix that is different from the average case mix (either less or more healthy than the case mix represented by the standardized bid), the Medicare payment is adjusted upwards or downwards to reflect the enrollee premium payments, which are fixed at the standardized amount for each enrollee.

The above system relates to Medicare payments for Part A and Part B services. When a plan offers Part D prescription drug benefits as part of its package,

Figure 2 Setting a benchmark for regional PPOs



Note: PPO (preferred provider organization), MA (Medicare Advantage), FFS (fee-for-service).

it submits a separate bid for the Part D portion. Payment for the Part D prescription drug portion of the plan benefits is calculated separately, the same way as if the plan were offering a stand-alone prescription drug package. The *Part D Payment System* document in our “Payment Basics” series provides more information on this topic. The only difference from stand-alone prescription drug plans is that the MA plan may choose to apply some of its rebate payments to lower the Part D premium that enrollees would otherwise be required to pay.

Determining Medicare payment for regional MA plans

Aside from a few special payment incentives, payment for regional MA plans is determined like payment for local plans, except that the benchmarks are calculated differently (Figure 2).

CMS determines the benchmarks for the MA regional plans by using a more complicated formula that incorporates the plan bids. A region’s benchmark is a weighted average of the average county rate and the average plan bid. As directed by law, CMS computes the average county rate as the individual county rates weighted by the number of Medicare beneficiaries who live in each

county. The average plan bid is each plan’s bid weighted by each plan’s projected number of enrollees. CMS then combines the average county rate and the average bid into an overall average. In calculating the overall average, the average bid is weighted by the number of enrollees in all private plans across the country, and the average county rate is weighted by the number of all Medicare beneficiaries who remain in FFS Medicare. ■

¹ In 2017, after the transition is completed for all areas, a county benchmark will be at one of four quartile levels. The benchmark will be 95, 100, 107.5 or 115 percent of the FFS projected rate for that county for the year, with the quartile assignment depending on the relative FFS expenditure levels among counties during the preceding year. If a county changes its quartile position from one year to the next, the percentage of FFS amount determining the county benchmark will be the average of the two percentages in each of the different years.